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Prescription Drug Prices: Harnessing Medicare's Purchasing Power

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In his State of the Union address this year, President Bush urged members of Congress to work with him to help control the rising costs of medical care. Just months ago, however, the President worked with Congressional leaders to block attempts to control the fastest growing health care cost: prescription drugs. The Medicare prescription drug benefit that the President signed into law and lauded in his speech omits any effective mechanisms to lower prescription drug prices. Instead, the President and Congressional leaders drafted the law with the intent of emulating the private market practices that have brought us to where we are today – exploding prescription drug costs that are increasingly borne by patients due to health insurers' restructuring of drug benefits.[1] Even if the Medicare program experiences similarly unsustainable costs, the new law expressly forbids the Secretary of Health and Human Services from acting to ensure reasonable prices under the drug benefit.

This report, the first in a series on the new Medicare law and its implications for beneficiaries and taxpayers, examines the law's provisions regarding prescription drug prices. After identifying concerns with the legislation as passed, the report offers options for legislative changes that would lower drug costs for Medicare beneficiaries and taxpayers.

WHAT THE LAW DOES

The new Medicare law relies on private drug plans (e.g., HMOs and other private health insurers), in conjunction with pharmaceutical manufacturers, to establish the prices beneficiaries and taxpayers will pay for prescription drugs under the Medicare drug benefit. Moreover, it states, "In order to promote competition under this part and in carrying out this part, the Secretary (1) may not interfere with the negotiations between drug manufacturers and pharmacies and [prescription drug plan] sponsors; and (2) may not require a particular formulary or institute a price structure for the reimbursement of covered Part D drugs."[2]

CONCERNS ABOUT THE LAW

The use of multiple private plans in multiple regions undermines Medicare's negotiating power. Medicare covers more than 40 million seniors and disabled Americans who are projected to consume $1.8 trillion worth of prescription drugs over the next decade.[3] Pharmaceutical companies, like other industries, grant discounts in exchange for volume and market share. It stands to reason, then, that Medicare can get the best prices on prescription drugs by leveraging its group purchasing power – just as Canada, other nations and other large payers in the United States do. States have recognized the importance of leverage by pooling purchasing activities across state agencies and by forming multi-state coalitions to negotiate drug prices. Instead, the new Medicare law relies on multiple private insurers in each of multiple regions to negotiate separate arrangements with pharmaceutical manufacturers. This dilutes Medicare's bargaining position.

The "noninterference" clause leaves Medicare powerless to prevent or address unfair prices. The noninterference clause poses problems beyond rejecting the use of Medicare's purchasing power to lower drug prices. It likely prevents the Secretary, when implementing the new prescription drug benefit, from setting key ground rules that might prevent conflicts of interest or promote lower prices. It also potentially limits the ability for Medicare to monitor what it pays for drugs, both opening up the possibility for overpayments and restricting the ability to collect data that could be used for future determinations about the cost-effectiveness of prescription drug coverage.[4]

IMPROVEMENTS

The "noninterference" clause must be removed. The obvious intent of the language is to prohibit the Secretary from influencing drug prices, directly or indirectly, under the Medicare drug benefit. Beyond its direct effect, it also has the potential to be used to interfere with attempts at program oversight – not just those relating to drug prices. The language is so broad that it could conceivably be invoked to challenge virtually any regulation. For example, the law requires drug insurers to have sufficient numbers of participating pharmacies to ensure "adequate emergency access" to pharmacies.[5] Any attempt by the Secretary to specify the types of arrangements that would satisfy this requirement could be challenged as

"interfering" with negotiations between insurers and pharmacies – even if the Secretary's specifications have nothing to do with drug prices in emergency situations or otherwise.

The Secretary must be given authority to negotiate drug prices. Removing the "noninterference" clause is necessary but not sufficient to ensure fair drug prices under the Medicare benefit. To leverage Medicare's bargaining power, the Secretary of Health and Human Services should be given the authority to negotiate with pharmaceutical manufacturers to establish the maximum price at which prescription drugs will be made available to Medicare beneficiaries. The Secretary's negotiation authority could be structured in any number of ways, all designed to achieve a fair price for beneficiaries and taxpayers while considering the need for pharmaceutical manufacturers to achieve a reasonable rate of return on their research and development investments. Outlined below are examples of legislative options that would enhance Medicare's ability to achieve that goal. They are neither detailed nor exhaustive policies. Instead, they are intended to serve as a starting point for discussion.

Negotiation for drugs with few alternatives. Congress could provide the Secretary with negotiating authority for certain types of prescription drugs that offer the greatest potential for savings through national negotiations. For example, pharmaceutical benefit managers (PBMs) generally secure rebates from manufacturers in exchange for favoring the manufacturer's products over competing products. In those cases where there are no competing products (e.g., sole-source drugs), PBMs have little leverage and the Secretary's authority might yield better results. Similarly, negotiations might be targeted toward drugs for which there are few therapeutic alternatives or drugs that are of particular clinical importance to Medicare beneficiaries. These negotiated prices for this subset of drugs would be used by all HMOs and private insurers delivering the drug benefit to Medicare beneficiaries.

Benchmarked negotiation. Congress could create a "benchmark price" system similar to what is used by the Department of Veterans Affairs and some state Medicaid programs. The Secretary would establish a benchmark, perhaps based on average prices paid by other federal and non-federal purchasers or other countries. Medicare and its beneficiaries would be guaranteed these discounted prices. In addition, HMOs and private insurers delivering the Medicare drug benefit could negotiate even lower prices with manufacturers in exchange for preferential coverage or other volume factors. Some experts assert that private insurers can achieve larger price discounts than the Secretary could negotiate.[6] Rather than rely on such an untested theory, a benchmarking approach would ensure that Medicare, its beneficiaries, and taxpayers would pay reasonable prices for prescription drugs if the private insurers fail.[7]

"Fallback" plan with Secretary-negotiated prices. Congress could create a Medicare prescription drug plan that would pay for drugs using Secretary-negotiated prices. This Medicare plan would be available in all areas of the country and would be paid in the same way that the law's regional "fallback" plans get paid.[8] Under this proposal, the plan offering Secretary-negotiated prices would compete with HMOs and private insurers. This policy ensures that Medicare beneficiaries have the choice of enrolling in a plan with the best prices, whether those prices are negotiated by private insurers or the Secretary.

Triggered negotiation. Congress could let the HMOs and private insurers negotiate prices unless and until they fail to contain Medicare drug cost growth – at which point the system would be replaced by one in which the Secretary negotiates prices. For example, Secretarial negotiations could be triggered if overall Medicare spending or spending growth exceeds what the Congressional Budget Office projected in December 2003.[9] This could be done either at the regional or national level. For example, CBO projected that Medicare drug costs will increase at an average annual rate of 11% between 2007 and 2013. If actual drug cost growth exceeds this amount, then Medicare would pay for prescription drugs based on Secretary-negotiated prices rather than the inflated private insurer rates. This model ensures that Medicare will step in when private insurers fail to perform as expected.

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[1] National Health Expenditures data. http://www.cms.hhs.gov/statistics/nhe/historical/highlights.asp
[2] §1860D-11(i)
[3] Douglas Holtz-Eakin, Director of the Congressional Budget Office, Testimony before the US House Committee on Ways and Means, April 9, 2003. http://www.cbo.gov/showdoc.cfm?index=4159&sequence=0
[4] Note: the issue of oversight and assessing the comparative effectiveness of prescription drugs will be topics for future issue briefs.
[5] §1860D-4(b)(1)(C)(iii)
[6] Letter from Douglas Holtz-Eakin, Director of the Congressional Budget Office, to Senator Frist, January 23, 2004.
[7] This approach is supported by AARP: http://www.aarp.org/prescriptiondrugs/informed/Articles/a2004-01-16-rxnext.html.
[8] Fallback plans are non-risk bearing organizations that will be available in areas with an insufficient number of insurers.
[9] Because Congress intended private insurers to control utilization as well as price, the proposed trigger is based on overall cost growth.